Dental Summary of Benefits
Group # 815151

Calendar Year Deductible*: **$50 ($100 per family)**
Calendar Year Maximum: **$2,000 per person**
Lifetime Orthodontic Maximum: **$1,500 per person**

* Waived for Diagnostic, Preventive & Orthodontic Services

COVERED SERVICES	Plan Pays***	You Pay**
Diagnostic & Preventive Services ➢ Routine oral exams & Routine cleanings (twice per calendar year) ➢ X-rays – complete mouth (once every 5 years); Bitewings (twice per calendar year through age 13, Once per calendar year thereafter); ➢ Sealants (through age 15): permanent molars only ➢ Emergency treatment for relief of pain ➢ Fluoride treatment (twice per calendar year through age 18)	**100% of Allowed Amount**	**To participating dentist: 0%** To non-participating dentist: any charges in excess of the Allowed Amount.
Basic Services ➢ Amalgam fillings, composite resin & stainless steel crowns - (United Concordia covers amalgam fillings on posterior teeth. If you choose a composite resin filling, you pay the difference). ➢ Simple extractions & complex oral surgery ➢ Endodontics ➢ General Anesthesia (in conjunction with covered dental surgery) ➢ Non-surgical and surgical periodontics ➢ Repair of denture and bridgework	**80% of Allowed Amount**	**To participating dentist: 20% + Deductible** To non-participating dentist: 20% of Allowed Amount. + any charges in excess of the Allowed Amount.
Major Services ➢ Inlays, onlays & crowns ➢ Removable partial or complete dentures & fixed bridges	**50% of Allowed Amount**	**To participating dentist: 50% + Deductible** To non-participating dentist: 50% of Allowed Amount. + any charges in excess of the Allowed Amount.
Orthodontic Services (No Deductible) ➢ Diagnostic, active and retention treatment	**50%**	**50%**

** United Concordia's National Fee-for-Service participating providers agree to accept United Concordia's allowed amount for covered services and also agree to file claims for you. You pay the deductible, coinsurance, and any charges for non-covered services. If you or your family members receive services from a non-network provider, United Concordia will reimburse you the allowed amount for covered services and you will be responsible for any amount that exceeds the United Concordia allowance, if applicable.

*** Subject to annual maximums , lifetime orthodontic maximums, limitations and exclusions.

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With 25 years of dental health management experience, United Concordia is a recognized leader in the dental benefits industry. United Concordia is the fifth largest dental insurer in the United States and currently covers more than 6 million members.

✓ **Freedom to choose any United Concordia National Fee-for-Service participating dentist**. You have direct access to specialists. No referral is necessary. You may change dentists as often as you like without notifying United Concordia.

✓ **Greatest savings by seeking services within the network.** Because participating dentists have agreed to a pre-negotiated fee (allowed amount), you pay less money out of your pocket since you pay your portion of the coinsurance on a reduced charge.

✓ The ***Concordia Flex*** dental program is network based. The plan offers access to an extensive dental provider network, including more than 56,300 dentists nationally and our growing network of more than 900 dentists in Arizona, from which you may seek care and receive benefits. Whenever dental care is needed, simply select a dentist from your United Concordia National Fee-for-Service participating dentist directory and contact the dentist's office to make an appointment. Or you may access the United Concordia National Fee-for-Service participating dentist directory on the internet at www.unitedconcordia.com.

✓ **United Concordia National Fee-for-Service participating dentists WILL:**

1. File your claim with United Concordia
2. Accept payment from United Concordia for covered services
3. **Accept United Concordia's allowed amount as payment in full.** You will be responsible for your co-insurance, deductible and any other services not covered under this plan.

✓ **Non-Participating Dentists:** You will file your own claim. Your out-of-pocket costs will be greater because United Concordia will reimburse you the allowed amount and you will be responsible to the dentist for the total amount due. You may be balanced billed the difference between the allowed amount and the dentist's actual charges.

✓ **Pre-determination:** When your dentist recommends dental services, we STRONGLY ADVISE that he or she submit a treatment plan to United Concordia for a Pre-determination of Benefits. This way you'll know in advance if the recommended treatment is a covered benefit, how much United Concordia will pay, and what your financial obligation will be.

✓ **Alternate Treatment –** United Concordia covers the least expensive most commonly used and accepted American Dental Association treatment. For example: United Concordia covers amalgams fillings on posterior teeth. If you choose a composite resin filling, you pay the difference.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

Except as specifically provided in this Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed as a covered benefit.
2. Which in the opinion of the dentist are not clinically necessary for the member's health.
3. Which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed Treatment Plan.
4. Started by any dentist prior to the member's eligibility under the Company, including, but not limited to endodontics, crowns, bridges, inlays, onlays, and dentures.
5. Incurred prior to the Member's Effective Date or after the Termination Date of coverage with the Claims Administrator, except those services as provided for in the Extension and Continuation of Benefits sections of this Certificate.
6. That do not meet accepted standards of dental treatment, which are Experimental or Investigational in nature or are considered enhancements to standard dental treatment as determined by the Claims Administrator.
7. For hospitalization costs.
8. Determined by the Claims Administrator to be the responsibility of Worker's Compensation or Employer's Liability, services for which benefits are payable under any Federal Government or state program, or for services for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy.
9. For prescription drugs.
10. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically described on the Schedule of Benefits.
11. Which are Cosmetic in nature as determined by the Claims Administrator. Including but not limited to implants, posterior composite filings, bleaching.
12. Elective procedures including the prophylactic extraction of third molars.
13. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect.
14. For any dental or medical services performed by a physician and/or services which benefits are otherwise provided under a medical-surgical plan of the Member.
15. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft palate therapy, treatment related to disharmony of facial bone, treatment related to or required as the result of orthognathic surgery including orthodontic treatment, dental implant services including placement and restoration of implants, and oral and maxillofacial and temporomandibular joint services including associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth, all treatment of temporomandibular disorders (TMD, TMJ, CMD, MFPD etc.), both surgical and nonsurgical treatment, arthroscopy of the joint and orthognathic surgery, and treatment of any malocclusion involving joints or muscles by orthodontic repositioning of the teeth. This exclusion shall not apply to newly born children of Members if such services are not covered under the employer's group medical plan.
16. For treatment of fractures and dislocations of the jaw.
17. For treatment of malignancies or neoplasms.
18. Procedures requiring appliances or restorations (except when involving full or partial dentures) that are necessary for adult or pediatric full mouth rehabilitation, including precision attachments or stress breakers, restoration of occlusion, to alter vertical dimension of occlusion, restorative equilibration and kinesiology.
19. For the cost to replace lost, stolen or damaged prosthetic or orthodontic appliances.
20. Deemed by the Claims Administrator to be of questionable efficacy.
21. For broken appointments.
22. Which are not Dentally Necessary as determined by the Claims Administrator.
23. For house calls for dental services.
24. For any service for which the Member failed to follow the guidelines of the Claims Administrator.
25. Full Mouth Debridement.

LIMITATIONS

The following services will be subject to limitations as set forth below:

1. Full mouth x-rays – once every five years.
2. Two sets of bitewing x-rays per calendar year through age thirteen, and one set of bitewing x-rays per calendar year for age fourteen and older.
3. Periodic oral evaluation – twice in a calendar year.
4. Limited oral evaluation (problem focused) – limited to one per Member per dentist per twelve months.
5. Prophylaxis – twice in a calendar year.
6. Fluoride treatment – twice in a calendar year through age eighteen.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous teeth and permanent first molars, or deciduous teeth and permanent first molars that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy – two per year per member in addition to routine prophylaxis.
11. Periodontal scaling and root planing - one per twenty-four month period per area of the mouth.
12. Placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five year of their placement.
13. Denture relining or rebasing - integral if provided within six months of insertion by the same dentist.
14. Subsequent denture relining or rebasing -- limited to one every thirty-six months thereafter.
15. Surgical periodontal procedures - one per twenty-four month period per area of the mouth.
16. Sealants - one per tooth per three years through age fifteen on permanent first and second molars.
17. Pulpal therapy - through age five on primary anterior teeth and through age eleven on primary posterior teeth.
18. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the ABP.
19. Root canal therapy – limited to one per tooth per lifetime.
20. Orthodontic therapy – available to covered adults and dependent children. Treatment for dependent children is limited to age 19 (or to age 25 if a full-time student) and not before the eighth (8) birthday.